49-20-101. Title.

This chapter is known as the "Public Employees' Benefit and Insurance Program Act."

Renumbered and Amended by Chapter 250, 2002 General Session

49-20-102. Definitions.

As used in this chapter:

(1) "Covered employer" means an employer that offers employee benefit plans under this chapter to its employees and their dependents.

(2) "Covered individual" means an employee and the employee's dependents eligible for coverage under this chapter.

(3) "Employee Benefit Plans" means any group health, dental, medical, disability, life insurance, medicare supplement, conversion coverage, cafeteria, flex plans, or other program for covered individuals administered by the Public Employees' Benefit and Insurance Program.

(4) "Employer" means the state, its political subdivisions, and educational institutions.

(5) "Program" means the Public Employees' Benefit and Insurance Program.

Renumbered and Amended by Chapter 250, 2002 General Session

49-20-103. Creation of insurance program.

There is created for the employees of the state, its educational institutions, and political subdivisions the "Public Employees' Benefit and Insurance Program" within the office.

Renumbered and Amended by Chapter 250, 2002 General Session

49-20-104. Creation of fund.

(1) There is created the "Public Employees' Trust Fund" for the purpose of paying the benefits and the costs of administering this program.

(2) The fund shall consist of all money and interest paid into it in accordance with this chapter, whether in the form of cash, securities, or other assets, and of all money received from any other source.

(3) Custody, management, and investment of the fund shall be governed by Chapter 11, Utah State Retirement Systems Administration.

Renumbered and Amended by Chapter 250, 2002 General Session

49-20-105. Purpose -- Benefits are not a continuing obligation.

(1) The purpose of this chapter is to provide a mechanism for covered employers to provide covered individuals with group health, dental, medical, disability, life insurance, medicare supplement, conversion coverage, cafeteria, flex plan, and other programs requested by the state, its political subdivisions, or educational institutions in the most efficient and economical manner.

(2) The benefits provided to a covered individual under this chapter do not constitute a continuing obligation of the state, its political subdivisions, or educational institutions.

Amended by Chapter 406, 2012 General Session

49-20-201. Program participation -- Eligibility -- Optional for certain groups.

(1) (a) The state shall participate in the program on behalf of its employees.

(b) Other employers, including political subdivisions and educational institutions, are eligible, but are not required, to participate in the program on behalf of their employees.

(2) (a) The Department of Health may participate in the program for the purpose of providing health and dental benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's Health Insurance Act, if the provisions in Subsection 26-40-110(4) occur.

(b) If the Department of Health participates in the program under the provisions of this Subsection (2), all insurance risk associated with the Children's Health Insurance Program shall be the responsibility of the Department of Health and not the program or the office.

(3) A covered individual shall be eligible for coverage after termination of employment under rules adopted by the board.

(4) Only the following are eligible for Medicare supplement coverage under this chapter upon becoming eligible for Medicare Part A and Part B coverage:

(a) retirees;

(b) members;

(c) participants;

(d) employees who have medical employee benefit plan coverage at the time of their retirement; and

(e) current spouses of those who are eligible under Subsections (4)(a) through (d).

Amended by Chapter 130, 2007 General Session

49-20-202. Establishment of separate risk pools.

(1) The program shall establish separate risk pools for:

(a) state employees; and

(b) the Utah Children's Health Insurance Program.

(2) In accordance with participation standards established by the program, the following entities may elect to participate in the risk pool established under Subsection (1)(a):

(a) in accordance with Subsection (3)(b), an institution of higher education designated under Section 53B-1-102 with a total full-time equivalent enrollment of less than 18,000;

(b) an independent entity as defined in Section 63E-1-102; and

(c) a comprehensive regional college.

(3) (a) The program shall create risk pools for other covered employers separate from those created in Subsection (1) as determined by the program.

(b) (i) If an institution of higher education described in Subsection (2)(a) has 1,000 or more plan enrollees, the program shall establish a rate for the institution of higher education based 100% on experience; and

(ii) if the rate established under Subsection (3)(b)(i) is:

(A) less than the risk pool rate established for the state employees' risk pool, the program may include the institution of higher education in the state employees' risk pool described in Subsection (1)(a); or

(B) more than the risk pool rate established for the state employees' risk pool, the program shall create a risk pool for the institution of higher education that is separate from the state employees' risk pool under Subsection (1)(a).

Amended by Chapter 211, 2010 General Session
Amended by Chapter 318, 2010 General Session

49-20-301. Payments made by employer and employee.

The program shall be maintained on a financially and actuarially sound basis by payments from covered employers and covered individuals.

Amended by Chapter 240, 2003 General Session

49-20-401. Program -- Powers and duties.

(1) The program shall:

(a) act as a self-insurer of employee benefit plans and administer those plans;

(b) enter into contracts with private insurers or carriers to underwrite employee benefit plans as considered appropriate by the program;

(c) indemnify employee benefit plans or purchase commercial reinsurance as considered appropriate by the program;

(d) provide descriptions of all employee benefit plans under this chapter in cooperation with covered employers;

(e) process claims for all employee benefit plans under this chapter or enter into contracts, after competitive bids are taken, with other benefit administrators to provide for the administration of the claims process;

(f) obtain an annual actuarial review of all health and dental benefit plans and a periodic review of all other employee benefit plans;

(g) consult with the covered employers to evaluate employee benefit plans and develop recommendations for benefit changes;

(h) annually submit a budget and audited financial statements to the governor and Legislature which includes total projected benefit costs and administrative costs;

(i) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the employee benefit plans as certified by the program's consulting actuary;

(j) submit, in advance, its recommended benefit adjustments for state employees to:

(i) the Legislature; and

(ii) the executive director of the state Department of Human Resource Management;

(k) determine benefits and rates, upon approval of the board, for multiemployer risk pools, retiree coverage, and conversion coverage;

(l) determine benefits and rates based on the total estimated costs and the employee premium share established by the Legislature, upon approval of the board, for state employees;

(m) administer benefits and rates, upon ratification of the board, for single employer risk pools;

(n) request proposals for provider networks or health and dental benefit plans administered by third party carriers at least once every three years for the purposes of:

(i) stimulating competition for the benefit of covered individuals;

(ii) establishing better geographical distribution of medical care services; and

(iii) providing coverage for both active and retired covered individuals;

(o) offer proposals which meet the criteria specified in a request for proposals and accepted by the program to active and retired state covered individuals and which may be offered to active and retired covered individuals of other covered employers at the option of the covered employer;

(p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for the Department of Health if the program provides program benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's Health Insurance Act;

(q) establish rules and procedures governing the admission of political subdivisions or educational institutions and their employees to the program;

(r) contract directly with medical providers to provide services for covered individuals;

(s) take additional actions necessary or appropriate to carry out the purposes of this chapter; and

(t) (i) require state employees and their dependents to participate in the electronic exchange of clinical health records in accordance with Section 26-1-37 unless the enrollee opts out of participation; and

(ii) prior to enrolling the state employee, each time the state employee logs onto the program's website, and each time the enrollee receives written enrollment information from the program, provide notice to the enrollee of the enrollee's participation in the electronic exchange of clinical health records and the option to opt out of participation at any time.

(2) (a) Funds budgeted and expended shall accrue from rates paid by the covered employers and covered individuals.

(b) Administrative costs shall be approved by the board and reported to the governor and the Legislature.

(3) The Department of Human Resource Management shall include the benefit adjustments described in Subsection (1)(j) in the total compensation plan recommended to the governor required under Subsection 67-19-12(7)(a).

Amended by Chapter 28, 2012 General Session
Amended by Chapter 173, 2012 General Session

49-20-402. Reserves to be held -- Refunds.

(1) The reserves in a risk pool in a given fiscal year shall be maintained at the level recommended by the program's consulting actuary and approved or ratified by the board. If the reserves drop below that level, covered employers in the risk pool are required to cure any deficiency in the reserve.

(2) If substantial excess reserves are accrued above those required by this chapter, and the board determines that a refund is appropriate, a refund shall be made:

(a) to covered employers which shall then make a refund to covered individuals on the basis of the contribution of each to the plan; or

(b) directly to covered individuals on the basis of the contribution of each to the plan.

Amended by Chapter 130, 2007 General Session

49-20-403. Assistance to members in purchase of life, health, dental, and medical insurance after retirement -- Employment of personnel to administer section.

(1) The program may assist active and retired covered individuals and inactive covered individuals of the covered employers to purchase life, health, dental, and medical coverage on a group basis which can be continued after retirement under rules adopted by the board.

(2) The executive director may employ any personnel, including consultants, to administer this section.

Enacted by Chapter 250, 2002 General Session

49-20-404. Governors' and legislative paid-up group health coverage benefit -- Limitations -- Medicare supplemental coverage -- Spouse coverage -- Limitations.

(1) (a) Except as provided under Subsection (1)(b), the state shall pay the percentage of the cost of providing paid-up group health coverage under Subsection (3) for members and their surviving spouses covered under Chapter 19, Utah Governors' and Legislators' Retirement Act, or governors and legislators, as defined in Section 49-19-102, and their surviving spouses covered under Chapter 22, New Public Employees' Tier II Contributory Retirement Act, who:

(i) retire after January 1, 1998;

(ii) are at least 62 but less than 65 years of age;

(iii) elect to receive and apply for this benefit to the program; and

(iv) are active members at the time of retirement or have continued coverage with the program until the date of eligibility for the benefit under this Subsection (1).

(b) A governor or a legislator who begins service as a governor or legislator on or after January 1, 2012, and a surviving spouse of the governor or the legislator who begins service as a governor or legislator on or after January 1, 2012, is not eligible for the benefit provided under this Subsection (1).

(2) The state shall pay the percentage of the cost of providing Medicare supplemental coverage under Subsection (3) for members and their surviving spouses

covered under Chapter 19, Utah Governors' and Legislators' Retirement Act who:

(a) began service as a governor or legislator before July 1, 2013;

(b) retire after January 1, 1998;

(c) are at least 65 years of age; and

(d) elect to receive and apply for this benefit to the program.

(3) The following percentages apply to the benefit described in Subsections (1)(a) and (2):

(a) 100% if the member has accrued 10 or more years of service credit;

(b) 80% if the member has accrued 8 or more years of service credit;

(c) 60% if the member has accrued 6 or more years of service credit; and

(d) 40% if the member has accrued 4 or more years of service credit.

Amended by Chapter 410, 2013 General Session

49-20-405. Audit required -- Report to governor and Legislature.

The Insurance Department shall biennially audit the Public Employees' Trust Fund and programs authorized under this chapter and report its findings to the governor and the Legislature, but the commissioner may accept the annual audited statement of the programs under this chapter in lieu of the biennial audit requirement.

Renumbered and Amended by Chapter 250, 2002 General Session

49-20-406. Insurance benefits for employees' beneficiaries.

(1) As used in this section:

(a) "Children" includes stepchildren and legally adopted children.

(b) (i) "Line-of-duty death" means a death resulting from:

(A) external force or violence occasioned by an act of duty as an employee; or

(B) strenuous activity, including a heart attack or stroke, that occurs during strenuous training or another strenuous activity required as an act of duty as an employee.

(ii) "Line-of-duty death" does not include a death that:

(A) occurs during an activity that is required as an act of duty as an employee if the activity is not a strenuous activity, including an activity that is clerical, administrative, or of a nonmanual nature contributes to the employee's death;

(B) occurs during the commission of a crime committed by the employee;

(C) the employee's intoxication or use of alcohol or drugs, whether prescribed or nonprescribed, contributes to the employee's death; or

(D) occurs in a manner other than as described in Subsection (1)(b)(i).

(c) (i) "Strenuous activity" means engagement involving a difficult, stressful, or vigorous fire suppression, rescue, hazardous material response, emergency medical service, physical law enforcement, prison security, disaster relief, or other emergency response activity.

(ii) "Strenuous activity" includes participating in a participating employer sanctioned and funded training exercise that involves difficult, stressful, or vigorous physical activity.

(2) The beneficiary of a covered individual who is employed by the state and

who has a line-of-duty death shall receive:

(a) the proceeds of a $50,000 group term life insurance policy paid for by the state and administered and provided as part of the group life insurance program under this chapter; and

(b) group health coverage paid for by the state that covers the covered individual's:

(i) surviving spouse until remarriage or becoming eligible for Medicare, whichever comes first; and

(ii) unmarried children up to the age of 26.

(3) A covered employer not required to provide the benefits under Subsection (2) may provide either or both of the benefits under Subsection (2) by paying rates established by the program.

(4) The benefit provided under Subsection (2)(a) is subject to the same terms and conditions as the group life insurance program provided under this chapter.

Amended by Chapter 40, 2013 General Session

49-20-407. Insurance mandates.

Notwithstanding the provisions of Subsection 31A-1-103(3)(f):

(1) health coverage offered to the state employee risk pool under Subsection 49-20-202(1)(a) shall comply with the provisions of Sections 31A-8-501 and 31A-22-605.5; and

(2) a health plan offered to public school districts, charter schools, and institutions of higher education under Subsection 49-20-201(1)(b) shall comply with the provisions of Section 31A-22-605.5.

Amended by Chapter 127, 2012 General Session

49-20-408. Prohibition against certain uses of Social Security numbers.

Notwithstanding the provisions of Subsection 31A-1-103(3)(f), health, dental, medical, Medicare supplement, or conversion coverage offered under Section 49-20-202 shall comply with the provisions of Section 31A-22-634.

Enacted by Chapter 188, 2003 General Session

49-20-409. Long-term disability -- Cost of health coverage benefit.

(1) Under the direction of the board, the program shall provide for health insurance coverage for state employees who receive a monthly disability benefit under Title 49, Chapter 21, Public Employees' Long-Term Disability Act.

(2) A risk pool, other than the state risk pool, may elect to provide a benefit for its employees similar to the benefit provided under Subsection (1).

Amended by Chapter 130, 2007 General Session

49-20-410. High deductible health plan -- Health savings account -- Contributions.

(1) (a) In addition to other employee benefit plans offered under Subsection 49-20-201(1), the office shall offer at least one federally qualified high deductible health plan with a health savings account as an optional health plan.

(b) The provisions and limitations of the plan shall be:

(i) determined by the office in accordance with federal requirements and limitations; and

(ii) designed to promote appropriate health care utilization by consumers, including preventive health care services.

(c) A state employee hired on or after July 1, 2011, who is offered a plan under Subsection 49-20-202(1)(a), shall be enrolled in a federally qualified high deductible health plan unless the employee chooses a different health benefit plan during the employee's open enrollment period.

(2) The office shall:

(a) administer the high deductible health plan in coordination with a health savings account for medical expenses for each covered individual in the high deductible health plan;

(b) offer to all employees training regarding all health plans offered to employees;

(c) prepare online training as an option for the training required by Subsections (2)(b) and (4);

(d) ensure the training offered under Subsections (2)(b) and (c) includes information on changing coverages to the high deductible plan with a health savings account, including coordination of benefits with other insurances, restrictions on other insurance coverages, and general tax implications; and

(e) coordinate annual open enrollment with the Department of Human Resource Management to give state employees the opportunity to affirmatively select preferences from among insurance coverage options.

(3) (a) Contributions to the health savings account may be made by the employer.

(b) The amount of the employer contributions under Subsection (3)(a) shall be determined annually by the office, after consultation with the Department of Human Resource Management and the Governor's Office of Management and Budget so that the annual employer contribution amount reflects the difference in the actuarial value between the program's health maintenance organization coverage and the federally qualified high deductible health plan coverage, after taking into account any difference in employee premium contribution.

(c) The office shall distribute the annual amount determined under Subsection (3)(b) to employees in two equal amounts with a pay date in January and a pay date in July of each plan year.

(d) An employee may also make contributions to the health savings account.

(4) (a) An employer participating in a plan offered under Subsection 49-20-202(1)(a) shall require each employee to complete training on the health plan options available to the employee.

(b) The training required by Subsection (4)(a):

(i) shall include materials prepared by the office under Subsection (2);

(ii) may be completed online; and

(iii) shall be completed:

(A) before the end of the 2012 open enrollment period for current enrollees in the program; and

(B) for employees hired on or after July 1, 2011, before the employee's selection of a plan in the program.

Amended by Chapter 310, 2013 General Session
Amended by Chapter 319, 2013 General Session

49-20-411. Autism Spectrum Disorder Treatment Program.

(1) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior that are:

(i) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and

(ii) provided or supervised by a board certified behavior analyst or a licensed psychologist with equivalent university training and supervised experience.

(b) "Autism spectrum disorder" is as defined by the most recent edition of the Diagnostic and Statistical Manual on Mental Disorders or a recent edition of a professionally accepted diagnostic manual.

(c) "Health plan" does not include the health plan offered by the Public Employees' Benefit and Insurance Program that is the state's designated essential health benefit package for purposes of the PPACA, as defined in Section 31A-1-401.

(d) "Parent" means a parent of a qualified child.

(e) "Program" means the autism spectrum disorder treatment program created in Subsection (2).

(f) "Qualified child" means a child who is:

(i) at least two years of age but less than seven years of age;

(ii) diagnosed with an autism spectrum disorder by a qualified professional; and

(iii) the eligible dependent of a state employee who is enrolled in a health plan that is offered under this chapter.

(g) "Treatment" means any treatment generally accepted by the medical community or the American Academy of Pediatrics as an effective treatment for an individual with an autism spectrum disorder, including applied behavior analysis.

(2) The Public Employees' Benefit and Insurance Program shall offer a program for the treatment of autism spectrum disorders in accordance with Subsection (3).

(3) The program shall offer qualified children:

(a) diagnosis of autism spectrum disorder by a physician or qualified mental health professional, and the development of a treatment plan;

(b) applied behavior analysis provided by a certified behavior analyst or someone with equivalent training; and

(c) an annual cost-shared maximum benefit of $30,000 toward the cost of treatment that the program covers, where, for each qualified child, for the cost of the

treatment:

(i) the parent pays the first $250;

(ii) after the first $250, the program pays 80% and the parent pays 20%;

(iii) the program pays no more than $150 per day; and

(iv) the program pays no more than $24,000 total.

(4) The purpose of the program is to study the efficacy of providing autism treatment and is not a mandate for coverage of autism treatment within the health plans offered by the Public Employees' Benefit and Insurance Program.

(5) The program shall be funded on an ongoing basis through the risk pool established in Subsection 49-20-202(1)(a).

Amended by Chapter 302, 2014 General Session

49-20-501. Title.

This part is known as the "Pharmacy Benefits Manager Act."

Enacted by Chapter 83, 2011 General Session

49-20-502. Definitions.

As used in this part:

(1) "Health benefit plan" means:

(a) a health benefit plan as defined in Section 31A-1-301; or

(b) a health, dental, medical, Medicare supplement, or conversion program offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(2) "Pharmacist" is as defined in Section 58-17b-102.

(3) "Pharmacy" is as defined in Section 58-17b-102.

(4) "Pharmacy benefits management service" means any of the following services provided to a health benefit plan, or to a participant of the health benefit plan:

(a) negotiating the amount to be paid by a health benefit plan for a prescription drug; or

(b) administering or managing prescription drug benefits provided by the health benefit plan for the benefit of a participant of the health benefit plan, including:

(i) mail service pharmacy;

(ii) specialty pharmacy;

(iii) claims processing;

(iv) payment of a claim;

(v) retail network management;

(vi) clinical formulary development;

(vii) clinical formulary management services;

(viii) rebate contracting;

(ix) rebate administration;

(x) a participant compliance program;

(xi) a therapeutic intervention program;

(xii) a disease management program; or

(xiii) a service that is similar to, or related to, a service described in Subsection

(4)(a) or (4)(b)(i) through (xii).

(5) "Pharmacy benefits manager" means a person that provides a pharmacy benefits management service to a health benefit plan.

(6) "Pharmacy service" means a product, good, or service provided by a pharmacy or pharmacist to an individual.

Enacted by Chapter 83, 2011 General Session

49-20-503. Request for proposals for pharmacy benefits manager for Public Employees' Benefit and Insurance Program.

(1) When the board issues a request for proposals for a pharmacy benefits manager to provide pharmacy benefits management services for the program, the request for proposals shall:

(a) require each responder to comply with the pharmacy audit provisions of Section 58-17b-622; and

(b) provide each responder with the option to include, among the billing options proposed, a billing option that complies with the requirements described in this section.

(2) The billing option described in Subsection (1) shall require the pharmacy benefits manager to, on at least a monthly basis, submit to the board an invoice for all pharmacy services paid by the pharmacy benefits manager on behalf of the program since the last request for payment or reimbursement.

(3) The invoice described in Subsection (2) shall state, as a separate item from any other amount:

(a) the total amount due to the pharmacy benefits manager for all pharmacy services billed in the invoice; and

(b) the total amount paid by the pharmacy benefits manager for the same pharmacy services for which payment is sought in that invoice.

Amended by Chapter 265, 2012 General Session